STATE LAB USE ONLY	
Sentinel ID #	
Lab ID #	
Received	
Reported	
Results	
Tech	

Wyoming Department of Health
Public Health Laboratory
208 S. College
Cheyenne, WY 82002
307-777-7431

REQUISITION FOR INFLUENZA TESTING

INSTRUCTIONS FOR INFLUENZA TESTING

- Specimens should be collected within 3 days of symptom onset
- Specimens should be collected & shipped according to attached protocol
- Specimens must arrive at the lab within 48 hours of collection
- Maintain Specimen at **2-4 ˚C** and ship on COLD PAK to the WPHL with the completed form

(Please print clearly with black ballpoint pen.)

Patient Name (Last) (First) (MI)

Patient Address **Home Phone** **( )**

Epidemiology Requested Case:

☐ **Yes** ***(outbreak / unusual case)***

☐ **No** ***(ILINet sentinel provider)***

Hispanic: ☐ **Yes** ☐ **No** ☐ **Unknown**

Race: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian or Pacific Islander** ☐ **White** ☐ **Unknown** ☐ **Other**

DOB / /

Age

Gender

☐ **Male**

☐ **Female**

Submitting Laboratory Name and Address (return address)

Phone Number **( )**

Fax Number **( )**

Attending Physician Name _____

COMPLETE ENTIRE SECTION BELOW TO ENSURE CORRECT TESTING INFORMATION

Date of onset of illness: _____/_____/_____

Rapid Flu Test Results:

☐ **Negative** ☐ **No rapid test performed**

☐ **A positive** ☐ **B positive**

☐ **A & B positive (Not Differentiated)**

SAMPLE TYPE	**DATE COLLECTED**
☐ **Nasopharyngeal swab**	_____/_____/_____
☐ **Nasal swab**	_____/_____/_____
☐ **Nasal wash/aspirate**	_____/_____/_____
☐ **Other**_____	_____/_____/_____

Was patient hospitalized? ☐ **Yes** ☐ **No**

If yes: Hospital _____

Date Admitted _____/_____/_____

Flu Vaccination ☐ **Yes** ☐ **No**

If yes, date received: _____/_____/_____

Nasal Vaccination ☐ **Yes** ☐ **No**

Patient Symptoms:

☐ **Sore throat** ☐ **Fever** ***(≥ 100.0 °F)***

☐ **Headache** ☐ **Nasal congestion**

☐ **Dry cough** ☐ **Shortness of breath**

☐ **Body Aches** ☐ **Diarrhea**

☐ **Vomiting** ☐ **Other** _____

Patient Name: _____ DOB: _____

Highest fever at home _____° F or ☐ N/A

Date taken: _____/_____/_____

Highest fever during *healthcare* visit _____° F

Travel outside USA? ☐ Yes ☐ No

If yes, list country: _____

Date of Travel _____/_____/_____

Did the patient receive antiviral medication?

☐ Yes ☐ No ☐ Unknown

If yes, complete the table below

Drug	Start Date	Number of days	Dosage
Tamiflu *(Oseltamivir)*			
Relenza *(Zanamivir)*			
Rimantadine			
Amantadine			
Other_____			

Does the patient have any of the following?

☐ Asthma

☐ Other chronic lung disease

☐ Cancer

☐ Neurological disease

☐ Kidney disease

☐ Chronic heart /Circulatory disease

☐ Metabolic disease *(including diabetes mellitus)*

☐ Obesity *(≥ 30.0 BMI)*

☐ Other Chronic Disease _____

Does the patient work in a healthcare facility/setting?

☐ Yes ☐ No ☐ Unknown

If yes: Facility _____

Address _____

_____

Pregnant?

☐ Yes ☐ No ☐ Unknown ☐ Not Applicable

If yes, how many weeks _____

Estimated due date: _____/_____/_____

Does the patient attend school?

☐ Yes ☐ No ☐ Unknown

If yes: School _____

Does the patient attend daycare?

☐ Yes ☐ No ☐ Unknown

If yes: Daycare _____

Patient's weight _____ kg or lbs

Patient's height _____ cm or ft/in

Part of a suspected cluster or outbreak?

☐ Yes ☐ No ☐ Unknown

If yes, list other possible cases

_____

_____

_____

Level *(s)* of medical care *(check all that apply)*

☐ Clinic visit *(outpatient)*

☐ Emergency Department / ER visit

☐ In-patient admission *(hospitalized patient)*

☐ Intensive Care Unit *(ICU)*

☐ Long-term Care Facility *(LTCF / Nursing home)*

☐ Other _____

Did the patient die? ☐ Yes ☐ No ☐ Unknown If yes, date of death: _____/_____/_____

If yes, location: ☐ Home ☐ ER ☐ Hospital ☐ ICU ☐ LTCF ☐ Other *(specify)*:_____

(Complete only if the patient died)

Requested autopsy? ☐ Yes ☐ No ☐ Unknown If yes, autopsy location _____

Invasive bacterial infection? ☐ Yes ☐ No ☐ Unknown If yes, list organism _____

Sterile site source: ☐ Blood ☐ Tissue ☐ CSF ☐ Pleural fluid ☐ Other *(specify)*:_____